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tel. (614) 442-1012 • fax (614) 442-7726
email: skincare@encoredermatology.com

Patient Information Form

Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Sex: M F Social Security #: _____

Patient Employer: _____ Patient Email: _____

Responsible Party:

Name: _____

Address: _____

Phone: _____

Whom may we contact in case of an emergency?

Name: _____ Phone: _____

Referring Physician's Name: _____

Referring Physician's Address: _____ Phone: _____

Insurance Subscriber Name: _____

Insurance Subscriber Address: _____

Insurance Subscriber Date of Birth: _____ Relation to Patient: _____

I hereby authorize the release of information regarding services rendered by the physician and allow a photocopy of my signature to be used to file insurance. I direct my carrier to issue payment for benefits to be made directly to the physician. Regardless of the insurance benefits, I understand that I am financially responsible for the fee for services rendered.

X _____

Signature: Date: